State Medicaid Information Center

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Volume Purchasing of Goods and Services in State Medicaid Programs

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VOLUME PURCHASING OF GOODS AND SERVICES IN STATE MEDICAID PROGRAMS

I. Introduction

Financial constraints are not a new problem for state governments, but they have become more severe over the past few years. This situation has increased the pressure upon states to contain the cost of their Medicaid programs, a significant budget item. As a result, Medicaid policymakers are searching for effective methods of reducing the growth in program expenditures.

Reductions in Medicaid spending resulting from administrative and management improvements are clearly a desirable option, particularly when compared with other alternatives such as reductions in the scope of benefits provided or the withdrawal of coverage from certain recipient groups. Unfortunately, there are a finite number of administrative remedies, and many states have already implemented a large number of them.

One approach to containment of costs -- volume purchasing of goods and services -- has been adopted by only a handful of state Medicaid programs.* Several reasons may be offered to explain this fact, including federal restrictions on the types of goods and services to which volume purchasing arrangements can be applied, states' uncertainty about potential savings, and various political and quality of care considerations.

However, recent changes in federal law have expanded the number of items and services for which states may enter into volume purchasing arrangements. In addition, those states who have implemented contract purchasing programs are unanimous in their belief that quality of services delivered has been improved and savings to the state have been realized. Many of these states are in fact considering extension of this method of purchasing to additional items and services.

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*Volume purchasing is only one of a number of terms used to identify similar approaches under which state Medicaid programs selectively arrange and pay for certain goods and services. Among the other terms used are contract purchasing, bulk purchasing and centralized purchasing. These terms will be used interchangeably throughout this report. Competitive bidding refers to the process most often used to select contractors.

While a careful analysis of a range of state-specific factors is necessary in determining the wisdom of volume purchasing of a particular item or service, this type of arrangement for state Medicaid programs certainly appears worthy of further consideration.

Section II presents a discussion of relevant Federal statutes and regulations, past and present; while Section III includes descriptions of various state volume purchasing programs and assesses their respective experiences. Section IV identifies the important elements to be considered in the decision as to whether bulk purchasing is appropriate for a state and the components which might be included in such a program. The Appendix contains a list of state staff persons contacted in the course of preparing this report.

II. Federal Statutes and Regulations Affecting Volume Purchasing

The section of the federal Medicaid statute (Title XIX of the Social Security Act) which in the past has been discussed most often in relation to the volume purchase of goods and services is 1902(a)(23), the "freedom of choice" provision, codified in regulations at 42 CFR 431.51. This provision guarantees Medicaid recipients the right to obtain services from any qualified provider they choose.

In a 1978 Information Memorandum, the Health Care Financing Administration (HCFA) took the position "that centralized purchasing is permitted as long as the State agency's action does not deny any choices which recipients now have." HCFA then interpreted the statute to permit:

> ...Medicaid recipients to choose freely among qualified providers, but it does not permit the Medicaid recipient to have any voice in the provider's choice of suppliers. Thus, Medicaid recipients will not be disadvantaged by centralized purchasing. The state will merely substitute its determination concerning choice of suppliers for the individualized determination of the providers.[1]

HCFA further clarified its interpretation by indicating that:

> the State is free to require in its provider agreement that opticians, optometrists or pharmacists obtain their drugs, lenses, or frames from designated suppliers which have already agreed with the State to furnish such supplies for a specified (presumably low) price.[2]

In an attempt to strengthen its position on volume purchasing, perhaps in response to a General Accounting Office report suggesting significant cost-saving potential in contracting for certain supplies and services,[3] HCFA published proposed regulations in the May 25, 1979 Federal Register. These would have added at 42 CFR 447.355 a new provision requiring State agencies to reimburse for eyeglasses and hearing aids on either an acquisition cost basis, a volume purchase plan basis, or a combination of both.[4] This proposed rule was never finalized although a number of states did in fact initiate bulk purchasing of eyeglasses.

In contrast to its position on the volume purchase of eyeglasses, the federal government in the past has viewed the volume purchase of independent laboratory

services as a violation of the freedom of choice provision. In 1975 New York State attempted to implement such a program in New York City. After completing a competitive bidding process and awarding sole rights for the provision of lab services to one vendor in each borough, the state was taken to court by a group of seven other vendors.[5] HCFA's predecessor agency within the federal government, the Social and Rehabilitation Service, entered the case as a friend of the court, siding with the plaintiffs and stating that the New York program violated Medicaid's freedom of choice requirement. The U.S. District Court placed a preliminary injunction on the lab services contracting program, prohibiting implementation in all but one borough, Queens. New York was given permission to conduct a pilot project there, an option which it declined.[6] The state also declined further court action and dropped the volume purchase program entirely.

Section 2175 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), however, amended the federal government's policy regarding the volume purchase of lab and x-ray services and clarified its policy toward volume purchase of certain other items. It added a new section 1915(a) to the Title XIX statute which explicitly stipulates that a state will not be found out of compliance with the statutory requirements for statewideness, comparability of services, and/or freedom of choice solely by reason of entering into "arrangements through a competitive bidding process or otherwise for the purchase of the laboratory services referred to in section 1905(a)(3) or of medical devices..."[7] The laboratory services referenced in the statute are defined at 42 CFR 440.30 as follows:

> 'Other laboratory and X-ray services' means professional and technical laboratory and radiological services – (a) Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory; (b) Provided in an office or similar facility other than a hospital outpatient department or clinic; and (c) Provided by a laboratory that meets the requirements for participation in Medicare.

HCFA's interpretation excludes inpatient hospital labs and those physicians' labs which do not process, per calendar year, at least 100 specimens per specialty for other physicians. The definition of "medical devices," as stated in the preamble to the new regulations, includes eyeglasses and hearing aids, as well as durable medical equipment, home health appliances, and prosthetics. Regulations to implement this new provision are codified at 42 CFR 431.54(d) and were published in interim final form in the October 1,1981 Federal

Register. The regulations do not specify what arrangements might be acceptable under the "or otherwise" category mentioned in the statute.

There are, however, some qualifications attached to the establishment of volume purchase programs. The statute requires that volume purchased lab services must be provided through a laboratory which meets Medicare requirements and which "has no more that 75% of its charges based on services to beneficiaries or recipients of Medicaid or Medicare."[8] In addition, although a state is not required to obtain a waiver to establish a contract purchasing program, the Reconciliation Act specifies that it must file a report with its regional HCFA office which provides the details of its program(s) and gives assurances that adequate services or devices will be available to recipients, and that the aforementioned requirements will be met in the case of laboratory service programs. The contract purchasing plan must be approved by HCFA before the state can begin implementation.

Although, in general, passage of the Omnibus Budget Reconciliation Act of 1981 has expanded the range of possible volume purchase options under Medicaid, it has muddied the waters somewhat with respect to the federal requirements concerning the establishment of a contract purchasing program for pharmaceutical goods. Such programs have been allowed in past years since, according to the 1978 HCFA Information Memorandum discussed earlier, states could require pharmacists to obtain drugs from supplier(s) with whom the state had contracted. Prior to passage of the Reconciliation Act, however, no state had chosen to implement such a program.

The House of Representatives' version of the bill included drugs along with lab and x-ray services and medical devices in the list of goods and services for which contract purchasing programs could now be implemented under the authority of 1915(a). But in developing the final, approved version of the Reconciliation bill, the House and Senate conferees reached an agreement which, according to the Conference Report, "eliminates drugs from the services which can be provided under these competitive bidding arrangements." (It should be observed that while the provisions of committee or conference reports do not have the force of law, they do provide an indication of Congressional intent, which in this instance might appear to run contrary to previously stated HCFA policies.)

Whether or not this is the case is somewhat clouded as the conference report then proceeds to refer the reader to a later discussion on drugs in Section 1915(b). This section indicates those instances where federal waivers of state plan requirements may be granted to allow restrictions to be placed on the selection of providers, and specifically includes drugs. This passage, in its reference to "drugs," appears, however, to relate to the dispensing services of pharmacists rather than to pharmaceutical products themselves--which suggests that perhaps drugs can be contract purchased without a waiver. Clarification of this issue is needed in order to properly identify the range of volume purchasing opportunities open to states.

It should be noted that, with respect to the volume purchasing or selective contracting for services, the provisions of the new section 1915(b) added by P.L. 97-35 substantially expand the options open to states which seek and receive federal waiver of certain state plan requirements. Subsection 1915(b)(1) allows states to implement a case management system which requires recipients to receive primary care services from one source, while subsection (b)(4) allows states to restrict recipients to the receiving of services (other than in emergency situations) from only efficient and cost-effective providers. One waiver application submitted by the State of California under the authority of this latter subsection would establish a program under which the state contracts through competitive bids, negotiations, or other means with select hospitals for the exclusive provision of Medicaid inpatient hospital services in certain areas of the state. Section 1915(b) thus theoretically allows state agencies to selectively contract for the full array of Medicaid services although such arrangements must be sanctioned by federal waivers.*

*A review of the waiver requests submitted under the authority of section 1915(b) of the Social Security Act is provided in the recent National Governors' Association publication, "Medicaid Freedom of Choice: A Review of Waiver Applications Submitted Under Section 2175 of the Omnibus Budget Reconciliation Act of 1981," August 1982.

III. State Medicaid Volume Purchasing Programs

Only a few state Medicaid programs have implemented volume purchasing arrangements, some as early as the mid-1970's, although a number are presently considering such programs. Table One on page eight presents the findings of a recent survey of volume purchasing activities conducted by the National Governors' Association's State Medicaid Information Center. It is useful to look at the various experiences and methodologies of these state programs because they suggest a variety of possible approaches.

A. Eyeglasses

The majority of the existent volume purchasing programs surveyed (eight out of fourteen) cover optical materials, i.e., eyeglasses and their component parts and, in a few cases, contact lenses. This may be largely due to the fact that, as discussed in the previous section, eyeglasses are one of the items for which federal guidelines have clearly allowed bulk purchasing, and that a bulk purchase eyeglass program may be perceived to be more easily administered than similar programs for other goods or services. In addition, these states may have seen a greater potential for savings on eyeglasses, either on the basis of larger volume or greater flexibility of price levels. A 1978 U.S. General Accounting Office study examined eyeglass costs for several Medicaid programs in Western states. The study showed that two states with volume purchasing programs were paying approximately 45 percent less than neighboring states without such programs. It observed that:

> In 1976 California paid about $7.2 million for Medicaid eyeglasses; however, based on Washington's competitively bid contract for eyeglasses, the cost would have been only $3.9 million. Likewise, Oregon paid $77,600 for eyeglass frames, whereas under Washington contract prices, the cost would have been only about $41,400.[9]

The range of contract purchasing programs for eyeglasses might best be discussed by breaking them down into two categories:

1. the "sole source" approach, in which one contractor supplies dispensers with all optical materials to be provided to Medicaid recipients, and;

A=Adopted
P=Proposed
C=Considering

TABLE ONE

STATE VOLUME PURCHASING PROGRAMS

	Drugs	Durable Medical Equipment (DME)	Eyeglasses	Hearing Aids	Laboratory Services	Oxygen	Respiratory Therapy	Other
Alabama			A					
Alaska				A[2]				
Arkansas			A					
California	P[1]	P[1]	P	P	P			
Connecticut			P					
Florida			A	A				
Iowa		C	P	C				
Kansas		C[3]						
Massachusetts	C	C	A	C	C	C		P/C[6]
Michigan	C		A	C	C			
Minnesota		P[5]	P[5]	P[5]				
Nebraska			P					
Nevada					P			
New Jersey		A[7]			P			
New York	C		C					
North Carolina			P					
North Dakota			C					
Oregon		C	C		C			
South Carolina		C	A	A[4]				
Washington		C[8]	A			A	A	
Wisconsin		C	A	C	C			

1. California plans to implement a drug rebate program. It also proposes to volume purchase wheelchairs and hospital beds.

2. Informal "coat-tail" arrangement; another state agency awards a contract on basis of competitive bidding process, and Medicaid reimburses at their contracted rates.

3. Proposal for volume purchase of DME, beginning with wheelchairs only.

4. South Carolina has a contractual arrangement with another state agency who contracts for hearing aids through a competitive bidding process.

5. The Minnesota legislature has mandated competitive bidding for these three categories of items.

6. Massachusetts is proposing volume purchase of dental crowns, and is considering it for non-emergency transportation and for dental braces, on a regional basis.

7. New Jersey operates a statewide DME loan closet which is used in appropriate situations (they also purchase and rent new DME when necessary). The vendor contract (for pick-up and delivery, storage and refurbishing) is negotiated rather than competitively bid.

8. Washington is considering implementation of some type of DME loan closet.

2. a contract with a central lab, with a provision that opticians, optometrists and ophthalmologists may obtain optical materials elsewhere with the understand ing that the state will pay no more for these supplies than the rates contracted with the central lab.

Programs falling within the first category have been adopted by Arkansas, Massachusetts, Michigan, South Carolina, Washington, and Wisconsin. Under a sole source system, the state contracts with one firm to supply all of the Medicaid program's optical materials, usually selecting the lowest qualified bidder through a competitive bidding process. A sole source contract, by guaranteeing a larger and relatively predictable volume of sales to a manufacturer, is likely to generate lower bids and thus lower costs. On the negative side, it has been suggested by some that this approach in some cases may be detrimental to small, minority-owned, and/or in-state optical labs, since they may not be able to match the low bids of larger companies. However, it may be possible, if so desired and if not prohibited by state law, to restrict competitive bidding to in-state labs or to make special provisions for small and/or minority labs in the contract (e.g., requiring sub-contracting arrangements where possible).

It may also be possible to encourage an arrangement similar to that in Massachusetts. When the state sent out its request for proposals, six New England optical labs joined together to form a consortium, won the bidding process, and are now operating as the sole provider of optical materials. The consortium has one central staff to process orders, but the labs still operate separately, and providers can choose among them.

Florida and Alabama have chosen the second type of volume purchasing program. They have each contracted with a "central lab" to provide optical materials to dispensers (opticians, ophthalmologists and optometrists) at an agreed-upon price. They allow the dispensers to purchase their supplies elsewhere if they wish; however, the state will pay no more to these dispensers for materials than the contracted rate charged by the central lab. In Alabama, about two-thirds of the program's optical materials are supplied by the central lab and, in Florida, over 90 percent.

Florida, incidentally, has an unusual arrangement which should be noted. A few years ago the state legislature enacted a law which required that state-contracted work be done by the Work Industries Program of the state prison system when feasible and when it would not impair quality. In accordance with this law, the Medicaid program did

not use competitive bidding to choose a contractor: They awarded their eyeglass contract to a women's prison, the Broward Correctional Institute, which was already providing eyeglasses for the entire Florida prison system. This arrangement began on a pilot basis, covering children's eyeglasses only. When it proved successful, they expanded it to adult glasses as well. Although there were some start-up problems with slow deliveries, the program currently seems to be working quite well.

With respect to their specific provisions and details, the eight state eyeglass programs reviewed have much in common, but also differ in a number of significant areas. Table Two lists the programs and some of the key elements of each.

There is a great range in the numbers of frames offered--from eight in Alabama to 60 in Arkansas. The argument against offering a small number of frames is that they are easily identifiable as "welfare glasses" and that this does not offer recipients a sufficient range of choices. The argument against requiring a large selection of frames is that it will cost more for the contractor to maintain a large inventory.

The process followed by states in their eyeglass contract purchasing programs is relatively uniform, with one variation. The dispensers usually send prescription forms directly to the contractor(s), who fill(s) them and mail(s) the eyeglasses to the dispensers for fitting and distribution to the recipients. The contractor and dispenser each bill the state or its fiscal agent separately for services rendered.

The variation chosen by several states affects the first step in the process. Michigan and South Carolina require that all eyeglasses be prior authorized, and in Kansas,* prescriptions must be sent first to the state for review, where the recipient's record is checked to determine his current eligibility and whether the maximum of one pair of eyeglasses every two years has been reached. Medical necessity is not evaluated. In all cases, dispensers send their prescriptions and prior authorization forms (or, in Kansas, "Optical Work Orders") directly to the Medicaid agency. Once a prescription is approved it is forwarded to the vendor, who fabricates the glasses and mails them to the dispenser. The advantage to this approach is that utilization is more carefully controlled.

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*Although Kansas does not practice contract purchasing, their method of "pre-adjucation" of eyeglass prescriptions may be of interest.

TABLE TWO

STATE EYEGLASS VOLUME PURCHASING PROGRAM CHARACTERISTICS

	Date of Implementation	Contract Type: Sole Source	Contract Type: Contract with a Central Lab; Other Labs Paid at Contract Rate	Competitive Bidding	Volume[1]: Units Filled	Volume[1]: Time Period	Number of Frames Offered	Contract Period	Recipient Limitations	Savings[1]
Alabama	1974		X	Yes	27,600 Orders	10/79-9/80	8	One Year	Adults: one pair every two calendar years Under 21: one pair per calendar year	Savings realized; amount not available
Arkansas	July 1970	X		Yes	20,000 Prescriptions	7/80-6/81	60	One Year	21+: one pr., exam per 2 yrs; no repairs or replacements; except: post-op cataract Under 21: one pair and exam per year	Data not available[2]
Florida	July 1980		X	No	50,000 Pairs	Annually	8	One Year	One pair every two fiscal years	$1.5 million the 1st year
Massachusetts	September 1981	X		Yes	About 120,000 Pairs	Annually	18	Two Years/ Option for a 3rd Year	Adults: 18-month repairs / replacement limit Under 21: no limits on repairs/replacement	Estimate: $1 million in 1st year
Michigan	June 1980	X		Yes	105,000 Pairs	10/30-9/81	34 dress 2 safety	One Year/ Option for a 2nd Year	Medical Necessity	Anticipated savings, 10/80-9/81: $500,000
South Carolina	November 1981	X		Yes	9,500 Pairs	Annually	18	Nine months/ Renewable	21+: post-surgical lenses only Under 21: as of 2/82, one pair per 12 months	Projected savings: $180,000 a year
Washington	October 1975	X		Yes	33,300 Orders	7/81-5/82	22 dress 2 safety	3 Years/ Fixed Price Contract, w/2 One-Yr. Options	One Pair Per Year	About 11-12 percent over cost of previous program
Wisconsin	April, 1982	X		Yes	19,000 Orders	4/82-7/82	30	1 year/ with 2 one-yr. options	1 complete appliance, 1 replacement per year, per provider	45%, or $1.5 million per annum (annualized, based on 4-month data)

[1] The data on volume and savings of state programs are estimates and do not cover identical time periods; they are in no way comparable and are provided here only to indicate the approximate sizes and cost savings of the programs.

[2] Arkansas' eyeglass program has been on a contract purchase basis from the outset; consequently, no comparative data on savings is available.

Kansas administrators, for example, believe that their approach has made it possible for them to negotiate lower rates, since the labs bear virtually no risk of losses through eligibility errors. The disadvantage of such prior authorization is, of course, a lengthier delivery or "turnaround" time, which will vary according to the volume of the program and to the level of efficiency and size of the state's review unit.

B. Hearing Aids

Medicaid experience with volume purchase of hearing aids is limited. Several states of varying sizes have indicated they have studied the matter and determined that, due to the limited volume of their hearing aid programs, the level of potential savings would not justify making it a high priority program. Our survey, however, reveals at least three state Medicaid programs with some variation of volume purchase of hearing aids.

For several years, the Alaska Medicaid program has maintained an informal arrangement which is reported to have saved the state close to 40 percent of the retail price of hearing aids. Another state program, the Communicative Disorders Program (C.D.P.), signs an annual contract with a single firm to fill their hearing aid needs at specified rates. The Medicaid program, which handles only between 100 and 130 hearing aids a year, in a sense rides C.D.P.'s coat-tails, setting its maximum reimbursement level at the C.D.P. contracted rate. The Medicaid Agency usually finds itself dealing with C.D.P.'s contractor because no other firm accepts the low rates. What is technically a fixed fee situation thus becomes, de facto, a sole source contract. Prior to implementation of this approach the state's reimbursement ceiling for hearing aids was $250. Under the present system, the average price paid for an aid is between $179 and $195.

South Carolina's Medicaid program has a more formal arrangement for providing hearing aids to its EPSDT recipients. It has contracted with the state's Department of Health and Environmental Control to obtain aids through the Department's Crippled Children's Program (CCP). The CCP annually awards sole source contracts to multiple manufacturers for various types of hearing aids. These are distributed to clients of both programs at Speech and Hearing Centers throughout the state. It is estimated that the Medicaid Program saves an average of $150 per hearing aid through this program.

Florida Medicaid purchases hearing aids in volume, contracting directly with manufacturers. Sixteen firms signed contracts in 1980, the program's first year; and in

1981, 22 have agreed to participate. The reimbursement process is as follows: The dispenser bills thestate for both the hearing aid and dispensing fee. He or she is paid the contracted price for the aid, plus his/her fee. (For services provided to adult recipients, the state deducts five percent from the payment to the dispenser since he/she receives a five percent coinsurance charge which is required of the recipient for hearing aids and related examinations.) The dispenser then passes the payment for the hearing aid on to the manufacturer. Although the dispenser receives an amount about 30 percent lower than the retail price, there is some flexibility in his budget due to the manufacturers' traditional practice of awarding discounts to him/her for large-volume purchases. Florida purchases between 3,000 and 3,500 hearing aids annually and pays an average price of about $130 to $150 for hearing aids; prior to this program, the average was $250.

Michigan recently considered the volume purchase of hearing aids. Its analysis explored several possible approaches, one of which was to purchase hearing aids, at one set rate for all aids, through a wholesaler rather than directly from the manufacturers. The rate would be set low enough to save the program money, but high enough to allow the wholesaler a profit margin, and would be based upon an average of charges for the range of aids purchased by the program. The state would deal with fewer contractors under this system and thus experience less administrative complexity, and it would be much easier to guarantee an approximate volume to a few wholesalers than to many manufacturers. However, the Michigan hearing aid program is relatively small (5000 aids a year) and savings would thus be relatively minor in comparison to the cost-saving potential of some other projects the state is exploring. Therefore, the state has decided to pursue those proposals which promise a greater return before undertaking a hearing aid volume purchase plan.

C. Laboratory and X-Ray Services

As mentioned in Section I, New York City attempted in 1975 to contract purchase independent laboratory services, but was enjoined by the courts. Now that P.L. 97-35 has brought federal acceptance of contract purchasing of these services, several states including California, Michigan*, Nevada, New Jersey and Wisconsin are looking at the possibility of implemention.

*Michigan is considering volume purchasing as an option in the future, but does not see it as an immediate source of savings. Therefore, they have recently lowered their screens for certain lab procedures.

The 1978 U.S. General Accounting Office report mentioned earlier in this paper discusses the relatively high rates paid for lab procedures by Medicaid programs, and examines various alternatives for lowering costs.

The Report explains several types of discounts available to lab users. Of one of these, the volume discount, the report says:

> Volume discounts are prevalent in the clinical laboratory industry, but the Medicaid program is not taking advantage of them. For example, when Federal agencies, with few exceptions, purchase clinical laboratory services, discounts ranging from ten to 25 percent may be obtained through use of the General Services Administration (GSA) Federal supply schedule price lists.[10]

Another type of discount, the professional discount, is granted to medical professionals. The G.A.O. report compared fees for one procedure, the T-4 (thyroid) test: New York State Medicaid paid $10 for the test. One of the labs it often dealt with charged, for the same test, $7.50 to private patients and $6 to physicians. A second lab charged $10 to private patients and $6.25 to physicians.

In its discussion of contract purchasing of lab services, the report cited a sole source contract entered into by New York City for pre-employment medical examinations for a group of 60,000 public assistance clients and job training applicants. The package of tests included a complete blood count, an SMA-12, a basic urine analysis, a serology and a drug screen. The rate paid by the City for this battery of tests was $6.25 per person tested. G.A.O. compared this rate with that of three Medicaid programs, Massachusetts, New Jersey and New York State, and found that they were paying from $14.70 to $25.50 for the same package.

Finally, the report said:

> Laboratory representatives stated that they offered better prices under contract because of anticipated guaranteed volume. Lower fees were also made available because specimens are picked up at a limited number of locations. In addition, they said that billing procedures were much simpler than those used by the Medicaid program.[11]

As impressive as these figures are, not all states will find it feasible or desirable to implement contract purchasing of lab services. Both Washington State and Illinois were, until recently, considering competitive bidding but have decided against it. Illinois' decision was based on the fact that they did not have sufficient staff or resources to perform all the analyses and preparations necessary prior to implementation.

Similarly, after carefully studying this and other alternatives, Washington determined that it could accomplish significant savings on lab services by reducing its reimbursement rates while avoiding the administrative complexities of volume purchase of lab services. The G.A.O. report identified appreciable savings that could be achieved through changes in reimbursement rates, noting that New York City, which is allowed a certain amount of independence under the New York State Medicaid program, established its own fee schedule for certain lab procedures, and its rates ranged from 50 to 60 percent lower than those of the state program.

D. Durable Medical Equipment

Durable Medical Equipment (DME) is obtained by state Medicaid programs in a number of ways. Often new or used equipment is purchased outright, but sometimes the more expensive items are rented for recipients' short-term needs. If their need for the item becomes a long-term one or if it extends beyond a specified time limitation, it is then often purchased.

Several states are considering contract purchase of DME. They include: California, Iowa, Kansas (for wheelchairs only), South Carolina and Wisconsin.

Washington has purchased oxygen in bulk for some time. It also volume purchases respiratory therapy services, which include ongoing rehabilitation and basic equipment necessary for the patient's treatment. Initial respiratory therapy and oxygen administration set-ups must be pre-authorized (any subsequent ongoing services need not). Both of these programs were originally set up as sole source arrangements with one contractor. In an informal legal interpretation of the contract, it was found that the sole source restriction could not be enforced, which allowed providers to purchase oxygen and respiratory therapy services from other sources, with reimbursement being limited to the contracted price. Current contracts have been rewritten as sole source agreements.

Savings can be realized under this arrangement. The 1978 GAO study compared oxygen reimbursement rates of three states. Oregon, whose reimbursement was based upon usual and customary rates, paid out $15,800 in 1976 for 256,844 cubic feet of oxygen purchased by eleven of their local offices. This averaged out to $6.15 per 100 cubic feet. If Oregon had been reimbursing at Washington's contracted rates, however, it would have

paid about $9,500, or an average of $3.70 per 100 cubic feet. For October 1976, California would have paid $42,064 for over one million cubic feet of oxygen, had it reimbursed at Washington's rate. Instead, it paid out $66,150 by reimbursing at the usual and customary rate, up to a given maximum amount.[12]

The 1978 HCFA Information Memorandum cited earlier identified an alternative open to states for providing at least a portion of the durable medical equipment needed by their recipients, stating:

> States are also free to purchase items of durable medical equipment (DME) and lend them to recipients through a loan closet arrangement. According to the then DHEW's General Counsel, there is no legal requirement that title to DME pass to the recipient. The state can maintain title and reclaim the items when the recipients no longer need them. However, all costs associated with the loan closet program (original purchase, storage, repair and delivery) would be considered as administrative and not program costs.[13]

New Jersey established a DME loan closet several years ago. The state retains title to durable medical equipment which it purchases, and when a Medicaid recipient no longer has need of it, it is reclaimed by the state. This procedure does not apply to Medicaid recipients also covered under Medicare. In the areas of New Jersey with heavier Medicaid populations, the state contracts with vendors to retrieve the equipment, refurbish it if necessary, store it, and deliver it to other clients as needed. In areas with fewer recipients, the state may pick up, deliver, and store the equipment itself and contract only for refurbishing. The contracts are not competitively bid, but, rather, negotiated. Selection of contractors is informal, sometimes through telephone surveys of vendors to determine those who will accept the rates proposed by the state. It is felt that, given the size of the DME program (less than $2 million) and the amount of savings realized through the loan closet program (probably under ten percent) that the cost of administering a competitive bidding process would make it an unprofitable alternative. However, the state is satisfied that its present program is saving it money.

The Washington State Medicaid program dropped its DME loan closet in the early 1970's, because the state, which administered the loan closet itself, found it extremely difficult to maintain inventories and track the equipment. Washington instead adopted a system of purchasing the equipment and passing ownership on to the recipients. Since that time, the DME program has grown significantly and the cost of certain new types of

equipment has become prohibitive. As a result, Washington is now re-evaluating the loan closet concept and considering administrative alternatives for such a program. One of the possibilities being considered is that of volume purchasing arrangements or provider contracts for statewide maintenance and administration.

E. Prescription Drugs

Drug expenditures accounted for 5.4 percent of the total Medicaid budget in Calendar Year 1981, according to HCFA data. While this is a relatively small proportion of total costs, it is still large enough to warrant the attention of policymakers looking for ways to lower program costs, particularly in the larger states where substantial dollar amounts are expended on drugs and drug services.

States have adopted various approaches in their efforts to hold down expenditures associated with their prescription drug benefit:

- One attempt to control Medicaid drug cost was the establishment at the federal level of the Maximum Allowable Cost (MAC) System, which establishes regional caps on what states can reimburse for certain types of drugs. With justification, individual states can establish MAC or Estimated Acquisition Cost (EAC) levels below that of the federal MAC.

- Another reimbursement-oriented approach has been to control the growth in the dispensing fee paid by the state to pharmacists or other providers of drugs.

- Many states have imposed on recipients copayments or cost-sharing requirements for prescription drugs. As of mid-1982, prescription drugs were the Medicaid service upon which states most often imposed a copayment requirements, with nearly half of the states having established such a policy.

- Some states have made reductions in their drug formularies, limiting the number of drugs they cover under the Medicaid program. These reductions are usually designed to: 1) eliminate high cost products where lesser cost substitutes are available, and/or 2) eliminate selected lower cost products for which the recipient would then have to pay. Nine states, representing nearly 45% of total Medicaid expenditures nationwide, were identified as having restricted formularies in early 1982.

It should be noted that each of these approaches is geared to reduce the level for one or both components of drug benefit expenditures: drug product costs and fees for pharmacists' or other dispensers' services. Although no data exist which disaggregate these two on the national level, Medicaid officials in several of the larger states suggest that the ratio for their programs is roughly two-thirds of their drug expenditures for drug products, and one-third for pharmacists' fees. One additional alternative which is designed to contain drug product costs is volume purchasing of drugs. Although the attitude of the federal government toward this is somewhat unclear, it appears that while a state's selective contracting with certain pharmacies for the distribution of drugs would not be permitted without a freedom-of-choice waiver, it might be acceptable for states to enter into volume purchasing arrangements with certain manufacturers of the pharmaceutical products these pharmacies dispense. (See Section II for further discussion).

No state has yet adopted a drug volume purchasing program but two -- California and Michigan -- are giving it serious consideration. This approach appears, understandably, to be more attractive to the larger states, whose higher drug volume would mean greater potential savings and thus a lower ratio of administrative costs to those savings, and whose larger staffs could better handle the detailed analyses and preparations necessary for such a program.

Although numerous variations are possible, three basic volume purchasing approaches have been identified in a preliminary analysis by the Michigan Medicaid program. This analysis also identified some of the advantages and disadvantages of each approach. The following is a synopsis of its findings:

1. State warehouse program. The state would purchase title to the drugs from manufacturers and/or wholesalers, take physical possession of them, and distribute them to participating pharmacies. In some states, this method may already be utilized under other programs to supply drugs to state hospitals or correctional facilities. The positive aspect of this approach is that vendors should be able to charge lower rates due to decreased shipping costs and to assurance of higher sales volume and timely payment by Medicaid. Pharmacies would not purchase Medicaid drugs, but rather serve as a conduit for them, and bill only for the dispensing fee. On the negative side, Medicaid administrative costs would increase in order to cover additional staff, ware-

house space, and distribution costs. The present drug distribution system would be disrupted and this approach would necessitate maintenance of dual inventories by pharmacies, as they would have to keep Medicaid drugs separate. This would mean more paperwork for them. Consequently, some pharmacies, particularly those with fewer Medicaid customers, might drop out of the program. The size of a state, both in terms of geography and population, and the number of pharmacies participating in Medicaid would be important factors in determining the feasibility of such a system.

2. Direct purchase program. Under this approach, the Medicaid program would purchase title to the drugs but would not actually take physical possession of them or be involved in the distribution process. The manufacturer/wholesaler would furnish the drugs to the pharmacies, replenishing their inventories as needed. Periodic payments would be made by the state to the manufacturer/wholesaler based upon the amount of drugs actually dispensed. The pharmacy would be reimbursed by Medicaid only for its professional fee. The benefit of this approach is that increased volume and assured timely payment should allow the manufacturer to lower the price to Medicaid. Disadvantages include disruption of the present distribution system: Pharmacies would be dealing with possibly multiple sources, the number depending upon the extent of state contracts; and dual inventories would be necessary. Again, pharmacies might be tempted to drop out of the program.

3. Manufacturer Discount, or Rebate Program. Manufacturers would be invited by the state to submit bids for post-purchase discounts. The winning bidder would be that manufacturer or wholesaler whose discount, when subtracted from the current reimbursement rate for a particular drug, would provide the lowest net cost to the state. The only change to the present reimbursement system would be that Medicaid would bill the manufacturer for the discount or rebate on a regular basis, using claims data. Lower net costs to Medicaid would be expected, due to an assured higher sales volume for the manufacturer.

   A major objection to this approach as voiced by the manufacturers concerns the need for monitoring to ensure that their product is actually dispensed to Medicaid recipients. They suggest that sample audits, which would be the only

feasible approach for most states, would not be sufficient to uncover every case of fraudulent claims reporting. On the other hand, state officials suggest that through random audits, together with follow-up of any tips from outside sources and of suspicious claims data, a significant proportion of fraudulent behavior could be uncovered.

California's Medicaid program (Medi-Cal) has exhibited a sustained interest in implementing some form of drug volume purchasing program. Discussions begun in 1971 eventually resulted in 1974 in an attempt to implement a pilot project within the state. The design of this project evolved from a state warehousing approach to the solicitation of rebate bids on certain pharmaceutical products. This project was cancelled in 1977 prior to its implementation due to intense lobbying of the state legislature by the drug manufacturers.

In 1981, interest was again rekindled in a drug volume purchasing program, with savings of $2 to $3 million projected for a statewide pilot focusing on 10 multi-source drugs. By October 1981, a benefit/cost ratio of 20:1 was projected for the project and the state had gone so far as to hire staff and begin selecting the specific drugs to be included in the program when questions raised about the existence of state legislation authorizing the program again forced its cancellation.

With the recent passage of state legislation (AB 799) providing clear authority to implement such a program, California is once again planning for implementation of its program, entitled the Prudent Purchase of Drugs (PPOD), beginning August 1983. Under the program, the state would request from manufacturers of from 50 to 150 multi-source drug products bids identifying what rebate or discount each would provide the state from their regular wholesale prices. Exclusive contracts would be awarded for each drug product to the manufacturers who offer the lowest net prices to the state (the current price minus the rebate). Medi-Cal would prevent manipulation of wholesale prices by including a stipulation that rebates would increase with prices, in order to maintain the same net price to the state during the contract period.

Pharmacists in the state would be required to provide the designated brands of the contracted drugs to Medicaid recipients, unless another brand was prior authorized (this would allow for those few individuals who might have an intolerance for a non-therapeutic, active ingredient of the state's brand). The pharmacists themselves would

continue to receive reimbursement at the current levels of the Maximum Allowable Cost (MAC) or Estimated Actual Cost (EAC) for drug product costs, plus their dispensing fee (currently $3.60). The state would then submit quarterly invoices to the designated manufacturers for the rebates owed. One concern raised by drug manufacturers is that they would have no way of knowing if their product was actually dispensed to Medi-Cal recipients or to private patients. They point out that there may be instances in which, depending upon the actual costs to the pharmacist of equivalent drugs, there might be an economic incentive for him to overstate the amount supplied to Medi-Cal patients. State officials intend to address this issue through overall monitoring of the program and focused audits of a sample of pharmacies. These officials also expect to avoid other implementation problems through careful program design. They believe the threat of overstocking wouldn't be a serious problem for the pharmacies, since dual inventories would not be necessary, and since pharmacists would have 90 days prior to the program's implementation to dispose of excessive stocks of other brands.

Michigan's interest in pursuing some form of volume purchasing of drugs was heightened by the finding that, of the top 226 Medicaid drug products, the prices under the state's warehouse operation for its Departments of Correction and Mental Health were 32% lower than those paid under its Medicaid program. The state could theoretically have realized savings of $8 million annually on these products had it been able to take advantage of these lower prices for its Medicaid drug purchases.

Some drug manufacturers have contended, however, that they can provide these lower prices under the state institutions' warehouse program because the bulk shipments to one or a limited number of sites substantially reduce their packaging and transportation costs. Michigan Medicaid, however, did not select a central purchasing and distribution system similar to the state warehouse operation because it was felt that such an approach would require a lengthy implementation period and would seriously disrupt the existing drug distributing and dispensing system.

Instead, Michigan, like California, opted to pursue a rebate program. As the first test of this approach it selected the cephalosporins, a group of second-generation antibiotics. Within this therapeutic classification, the state covered seven different, primarily single-source drugs, three of which were viewed as being able to handle nearly all of the infections the cephalosporins were meant to treat. Michigan designed a program under which requests for quotations were sent to manufacturers of each type of

cephalosporin covered under the Medicaid program. During the first half of 1982, each manufacturer was asked to indicate what rebate it would provide the state if it was selected as the only cephalosporin not to have a patient copayment requirement attached to it. This rebate would be paid only on the increase in Medicaid sales volume the manufacturer would experience as the result of being the only brand of cephalosporins without a copayment. The manufacturer whose bid would result in the greatest savings to the state was to be selected as the "preferred" Medicaid brand. These savings were to be estimated by multiplying the net savings or rebate per unit times the anticipated increase in the manufacturer's Medicaid sales resulting from greater patient selection of that brand.

Unfortunately, however, Michigan received no response to its request for quotations from the cephalosporin manufacturers. A second attempt at establishing a drug rebate program was made by soliciting quotations from manufacturers of non-steroidal anti-inflammatory drugs. Only one response to this solicitation was received , which the state is currently evaluating.

The difficulties these two states have faced in both gaining acceptance of and actually implementing a drug rebate program are reflective of the myriad complex issues associated with such an approach. A Michigan task force identified the following problems and/or issues which must be faced in order to implement a successful program:[14]

1. Manufacturers may not be willing to participate.*
2. How will the current costs for distribution (by wholesalers and chains) be calculated? This becomes quite complex when certain manufacturers offer the same price to a wholesaler as to a pharmacy.
3. What auditing technique would be used to ensure that the appropriate product was dispensed by the pharmacy? What would be the cost of auditing? (These concerns relate, in the main, to multi-source products).
4. How will the manufacturer gain confidence in a state Medicaid agency's product data as being the basis for determining the amount of the rebate?
5. How will the program handle new drugs?
6. Will the physician community accept the new program if drugs are eliminated?

7. What would be a state Medicaid agency's liability if drugs are eliminated?

8. A rebate schema may cause the manufacturer to increase the cost of drug products to other non-profit agencies.

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* It should be noted that, according to industry figures gathered by the American Druggist in a recent survey, Medicaid drug purchases accounted for 13.7% of the retail drug market in 1982.

IV. Implementing a Volume Purchasing Program

A. Determining the Appropriateness of Volume Purchasing

There are several reasons why a state Medicaid program might find volume purchasing an attractive approach to provider reimbursement. One of these is the quality issue: Quality of goods and services can be better controlled through contract specifications, and monitoring will be much simpler.

But the most important feature of volume purchasing by far is its potential for reducing costs. Unlike the quality issue, however, the relative advantage of volume purchase in terms of savings will be service- and state-specific. That is, while the evidence from existent state programs supports the cost-saving nature of volume purchasing, it may not hold true for every service or item for every state. A careful review must be made in order to assess the net impact on state expenditures.

However, before a detailed cost analysis is undertaken, state Medicaid policymakers might find it useful to look at the following considerations in determining the appropriateness of bulk purchasing of a specific item or service:

- o basic questions such as whether the state currently provides the item or service for which the federal government allows volume purchasing. The list of items and services for which volume purchasing arrangements can be established without a waiver includes: eyeglasses, hearing aids, lab services and x-rays, durable medical equipment, home health appliances, prosthetic devices, and perhaps drugs. The size of program expenditures for each of these items is also an important consideration in projecting savings.

- o whether significant changes in provision of this item are likely to occur within the foreseeable future. These might include the elimination of coverage for all or certain recipient groups, a reduction in the scope of the benefit in question, or the possible enrollment of a large group of recipients into a capitation program, such as a Health Maintenance Organization, which already covers the service or item being considered for contract purchasing.

- o the political situation in regard to the particular service. How powerful are the provider associations involved? What is their position on volume purchasing? Can they be expected to support such a program, particularly if they are allowed to help shape it?

- o the availability of administrative resources. For some items or services, even preliminary analyses of various approaches may indicate that the development and implementation of a volume purchasing program would require a substantial amount of staff resources, which are not available. (Illinois decided not to pursue volume purchasing of lab services partly for this reason.) Preliminary research would be particularly burdensome in areas where no state's Medicaid program has yet attempted volume purchasing and thus no data on costs or methodologies exist, such as drugs or lab services. If sufficient funds are not available, and yet the preliminary review indicates that significant cost savings might accrue from initiating such a program, consideration might be given to seeking funding in the next state budgetary process for the additional staff necessary to develop the approach.

- o all relevant legal points. Pertinent state statutes should be studied for prohibitions or qualifications. Any possible federal or state constraints should be checked out (e.g., before undertaking an extensive analysis in preparation for volume purchasing of drugs it would be wise to obtain a clarification of federal policy.)

- o other considerations specific to the goods or services being reviewed. For instance, geographic, demographic and transportation factors may determine whether contract purchase of lab services is feasible and what type of program is most suitable. Emergency lab work may be handled by the contract lab(s) in some states, but in others lower population densities may make it necessary to contract only for non-emergent services. Similarly, the integrity of some procedures would be harmed by shipping or by delays inherent in a centralized processing system.

If a volume purchase arrangement operated solely by the state Medicaid program does not seem feasible, there are alternative methods of containing costs through revision of the reimbursement structure. One of these is simply reducing current screens or payment ceilings, if they are relatively high, or establishing them if the state has no maximum other than reasonable and customary charges. In at least one state, the prospect of volume purchasing induced the provider group to request, instead, negotiations for the purpose of setting maximum payment rates.

Another option is a joint program with one or more other state agencies. South Carolina is providing hearing aids in this manner. A variation on this theme, practiced by Alaska, is a "coat-tail" arrangement whereby the Medicaid program will pay no more for a specific item or service than the rate that has been contracted by a sister state agency.

If it is decided that volume purchase of a particular item or service warrants further study, a careful analysis of costs and potential savings is in order. It is important to compare what the state's Medicaid program is currently spending with per unit expenditures of other states which are already purchasing by volume, if there are any existent state programs for this specific service or item. At this point, and throughout the process of analysis and preparation, it can be extremely useful to consult with staff persons in these states. A look at other volume purchasers such as the Veterans Administration or sister state agencies might also be helpful as would a survey of actual costs to vendors for the item or service. There are various factors which can affect the level of savings, including:

- o pertinent state laws concerning competitive bidding for state government contracts. For instance, state statutes may prohibit state agencies from contracting with out-of-state firms. This could present a problem if the only in-state vendors are small businesses and if even those that are capable of meeting the contract requirements are not able to provide the product at rates as low as those offered by larger, out-of-state producers. One solution might be to encourage the formation of a consortium of small vendors similar to the optical lab consortium contracting with the Massachusetts Medicaid program.

- o the decision as to whether or not to require prior authorization of the item or service. When this or a similar process involves a review of eligibility as well as medical necessity, it will lower the vendor's risk by virtually eliminating claim disallowance on the basis of ineligibility, and theoretically should allow vendors to lower the bids they tender.

- o anticipated volume of the item or service to be purchased. The larger the volume, the lower the rates are likely to be. Larger volumes can be achieved by entering into a joint bulk purchasing program with another state agency, as was discussed earlier.

- o whether it will be a sole source contract (which makes possible a better estimate of the volume to be purchased);

- o formulas for determining the proportion of costs covered by the federal government. It should be remembered that, while there is a 50/50 federal match for administrative costs; the FFP match for services, and therefore the non-federal share of both costs and cost-savings, varies from state to state. This should be factored into the calculations of actual savings accruing to the state.

Offsetting costs generally fall into two categories: start-up costs and operating costs. Once a program has been established, it will not be expensive to operate, but the initial outlays could be in some cases.

An estimation of the start-up costs is crucial. Even though the long-term savings potential may be large, if start-up costs will be high there may be no room in the budget to get the program up and running. Again, the preliminary costs will vary greatly depending upon the type of service being considered -- that is, how complex the program would be, how much research is necessary to design it, and how major are the necessary changes.

Systems changes are required prior to implementation of a volume purchasing program. These may in some cases account for a large portion of the program's start-up costs and, in other cases, they are minimal. It depends entirely upon the current claims system and upon how major will be the changes necessary to convert to the new purchasing program and its claims procedures. Many of the changes will be required because of the transition to a dual claims process: The dispenser will no longer submit one claim for both his fees and the cost of materials; in most cases claims for materials will be submitted directly by the contractor with the dispenser submitting a separate claim for his fee.

The development of both the initial Invitation for Bids (IFB), and the contract, and the entire competitive bidding process will take a certain amount of staff time and expense. This, again, can be minimized, sometimes significantly, by looking carefully at what other states have done. It may be that one state's program design will fit another's needs with only minor modifications. Other expenses may include consultant fees and/or costs associated with consultations and meetings with provider groups.

Once the approximate costs of a volume purchasing program have been estimated, the net savings of such a program can be projected. It is then up to the state Medicaid policymakers to determine whether such a program would be desirable, in light of the cost savings and any other non-cash considerations they may with to take into account.

B. Determining the Elements in a Volume Purchasing Program

Once the decision has been made to proceed with the development of a volume purchasing program there is much groundwork to be done prior to implementation.

As was mentioned earlier, it can be extremely helpful at the outset to look at how other states have set up their programs. From their experiences it is possible to select useful policies and methodologies and then to design a plan to suit a state's unique needs. This can save considerable staff time and resources. Appendix 1, which follows, presents a list of state Medicaid staffpersons who provided information about their volume purchasing programs for the preparation of this paper. Another source of assistance which may become available in the future is an Information Memorandum which HCFA is currently developing.

Once the new policies have been determined, the implementation process can be set in motion. Federal law does not require that a volume purchase contract be arrived at through competitive bidding: As noted earlier, the language of the Reconciliation Act calls for volume purchasing arrangements to be established through competitive bidding or "otherwise." There is thus a range of possible methods for selecting a vendor. Among these would be negotiation or, as in the case of Florida, a contract with a state institution's workshop (in its case, the prison sytem's optical lab). Many states, however, will probably choose competitive bidding, as state laws often require it as the method for selection of contractors.

The following discussion will focus upon the competitive bidding approach, but much of what is said would also apply to other methods of vendor selection.

It may be helpful to set up an internal task force consisting of representatives of the various state agencies or departments with expertise in pertinent areas. These might include those offices working with contracts and procurement, fiscal and legal matters.

In addition, the agency's claims processing staff or fiscal agent should be consulted early on. The preliminary feasibility study will have provided a cost estimate for systems changes, but now the actual groundwork must be done. Negotiations with the fiscal agent may be required if substantial modifications are to be made.

State laws must be examined carefully to determine whether or not legislative changes are needed to implement the program. Acting upon uncertain authority can lead sometimes to lengthy, expensive litigation. If new legislation is necessary, legislators must be persuaded of the value and potential savings of a bulk purchasing program.

The establishment of an advisory committee which includes representatives of concerned provider groups can be important in several ways. Their counsel, sought either through such a committee or in a more informal manner, will be useful in developing effective and acceptable procedures. It is also important to solicit provider groups' input at all stages of the planning and implementation processes in order to gain their cooperation and support.

Before the competitive bidding process can be implemented, numerous major and minor policy decisions must be made. The entire process to be followed must be worked out, from disposition of the prescription or provider's order for the item or service to the length of warranty. New forms may or may not need to be designed, claims procedures established, repair policies outlined, and the issue of dispensing fees addressed.

One basic decision to be made concerns the length of the contract period. Most of the states with volume purchasing agreements have chosen one year, often with provision for several one-year options to extend. The few states with longer contract periods may cut down on the frequency of performing administrative tasks involved in the bidding process (although once the initial IFB and contract are constructed, subsequent efforts are reduced considerably), while risking the possibility of being locked into a less than satisfactory arrangement. Most contracts do, however, include a clause allowing for "termination for convenience" when it is in the best interests of the state. If a long-term contract provides for fixed prices for the life of the contract, the state may accrue greater savings over a longer period. Care should be taken, however, not to place the contractor at too great a risk. This could reduce the number of bidders, raise the level of bids to a point where it will offset any potential savings derived from the longer term or, under adverse economic conditions, perhaps impair the contractor's ability to fulfill the contract.

Another matter of concern is the impact on small and minority businesses. States may attempt to acknowledge or to offset any detrimental effects by addressing this issue in their IFBs and/or contracts. Provisions vary from a brief reference to the fact that the state encourages these firms to apply, to a requirement included in Wisconsin's bid document for its eyeglass program that bidders must "expend a good faith effort to identify, contact and secure a qualified Minority Business Enterprise and/or a small Wisconsin Business" as a subcontractor. They must either secure such a subcontractor or document efforts to do so. If they do not, they will be disqualified from the bidding.

A maximum turnaround time, the time which elapses between the ordering of the item or service and its provision to the provider or recipient, should be determined, as well as penalties for failure to meet it. Prior authorization or adjudication would of course lengthen the turnaround time, but would, on the other hand, offer the aforementioned advantage of stimulating lower bids by reducing risk to the vendor.

Some states require a performance bond of the winning bidder-- insurance that the firm will fulfill the contract. Michigan specifies that the bond shall be ten percent of the contract, but not less than $5000. This is payable to Michigan if the contractor defaults on the contract. Wisconsin requires its winner to post a $50,000 performance bond.

Wisconsin has included a penalty clause in its eyeglass contract. A random sample of orders will be monitored over a three-month period. If, from that sample, five percent or more of the orders are not processed and delivered in a timely manner (Wisconsin requires delivery within ten working days of receipt of the prescription), the contractor will forfeit two percent of the amount claimed for reimbursement over that three-month period.

The Invitation for Bids (IFB), also known as the Request for Quotations, is an extremely important document. (A state may, alternatively, distribute a Request for Proposals, or RFP, which allows the bidder to propose methodologies as well as bids.) The IFB sets out the specifications by which potential bidders determine whether they can meet the terms of the contract and, if so, at what price. It should therefore be as detailed as possible, so there will be no confusion as to what will be expected of the contractor. The terms which will appear in the contract should be thoroughly laid out, except for those points which the state is willing to negotiate with the winner.

Some of the issues which would be appropriate to address in an IFB are as follows:

- bidding procedures to be followed, description of the award granting process and appeals procedures;
- how a tie in the bid selection will be handled (e.g., whether a minority or small business will receive preference);
- assurance by bidder that he will abide by the stated specifications and that his is a "firm offer";
- description of the tasks to be performed by the contractor and the processes involved;

- the estimated volume of purchases, with the stipulation that these are only estimates and that the contractor must be prepared to fill orders upon demand (if feasible, these should be broken down into regions);
- all quality standards which the items or services must meet;
- the contract length and the length and number of options to extend;
- time requirements for delivery of items;
- provision and requirements for contractor to report delays to dispensers and to the state;
- time limits on guarantees or warranties;
- method of reimbursement;
- method of billing: tape-to-tape or standard paper claims;
- requirement of periodic work or status reports by the contractor giving a tabulation of the orders filled under the contract;
- monitoring, on-site or otherwise (to ensure quality and contract fulfillment);
- procedures and financial responsibility for shipping (often shipping charges are paid by the contractor out of his reimbursement from the state; therefore, he needs to include consideration of these costs in calculating his bid);
- valid reasons for termination of the contract by the state and/or the vendor, and assignment of financial liability for associated costs;
- responsibility for repairs and/or replacements;
- non-discrimination clause;
- any special consideration for minority and/or small businesses;
- penalty clause (for delays, non-fulfillment of contract);
- various types of indemnity clauses protecting the state and its employees;
- performance bond, to be paid for by the winner and held by the state throughout the life of the contract (this is a type of insurance against non-fulfillment of contract);
- types of forms to be used and assignment of responsibility for their design, printing and distribution to providers;
- requirement of confidentiality of client information;
- reference to taxes (Will the state Medicaid program be charged sales tax by the vendor?);
- any limitations on location of bidders' labs (e.g., it may be stipulated that only in-state businesses need apply or that a certain percentage of the work must be done within the state--this is sometimes mandated by specific state laws;

- o time limitations in relation to claims: time allowed contractor to submit claims, and time allowed state to pay them;
- o for an eyeglass program: assignment of financial responsibility for frame sample kits to be used by dispensers (often dispenser purchases them, but there may be a loan arrangement);
- o any other provisions which the state finds appropriate, useful or necessary. These might include a toll-free telephone number for use by providers or dispensers, and/or required reporting of possible abusive or fraudulent behavior by providers or recipients.

The completed IFB must then be distributed. A state can choose to send it to selected bidders or it can use an open bidding procedure, publishing its IFB widely and making it available to any interested parties. Another question to be addressed is whether to limit the invitation to in-state contractors. This may be out of a state agency's hands, depending upon whether or not there are any in-state providers capable of handling the contract, and upon pertinent state laws and regulations.

After distribution of the IFB, it is wise to hold a Bidders' Conference to explain to potential bidders the program, the contract specifications, and to answer any questions they may have.

Bids, of course, should remain sealed until the official opening, to avoid any challenges to the agency's impartiality. The selection committee will no doubt wish, initially, to eliminate those bidders who do not qualify or who cannot be considered as "responsible," capable of fulfilling the contract, or financially viable (the IFB should include a statement that the state can reject a bid "with cause"). The state can then select the lowest bidder from the qualified group.

Once the winner is selected, any details not already agreed upon should then be negotiated, and the contract signed.

Before startup, the contractor will, of course, need a reasonable amount of time to gear up for the added volume and any new procedures required; and the claims processing and fiscal units must be given adequate time to make the necessary systems changes.

Essential to the success of the program is adequate education of the providers who will be ordering or prescribing the contracted item or service. Written notification can be made through special editions of Provider Bulletins and updates of provider manuals. Other effective techniques include speaking to conferences of provider associations, holding regional seminars for providers in order to discuss the new system, and consultation with provider association representatives. The more familiar providers become with the program, the smoother will be its operation and, thus, the lower a state's administrative costs.

Careful, thorough development of a volume purchasing plan will pay off. It will mean fewer unexpected, costly problems during the start-up period. Complete, detailed IFBs and contracts which spell out what is expected of the contractor and cover all contingencies will make the transition to volume purchasing easier for all concerned.

FOOTNOTES

1. HCFA Information Memorandum, HCFA-IM-78-48 (MMB) 10/23/78

2. Ibid.

3. U.S. General Accounting Office, Comptroller General's Report to the Congress of the United States: Savings Available by Contracting for Medical Supplies and Laboratory Services; HRD-78-60, July 6, 1978, pp. 5-6.

4. Medicaid Program: Reimbursement for Eyeglasses and Hearing Aids: Proposed Rule; Federal Register, Vol. 44, No. 103; Friday, 5/25/79.

5. Bay Ridge Diagnostic Lab, Inc. v. Dumpson, USDC (ED N.Y.), 400 F. Supp. 1104 (1975).

6. Conversation with Ralph M. Pogoda, Director, Program Standards and Policies Division of Medical Assistance, New York State Department of Social Services.

7 Omnibus Budget Reconciliation Act of 1981 (PL 97-35), Section 2175.

8. Section 1915(a)(1)(B)(ii) of the Social Security Act, which was established by Section 2175, Public Law 97-35.

9. U.S. General Accounting Office, op. cit.

10. Ibid.

11. Ibid.

12. Ibid.

13. HCFA Information Memorandum, op. cit.

14. Medical Services Administration, Michigan Department of Social Services, "Volume Purchase of Pharmaceutical Products for the Michigan Medicaid Program," April 26, 1982, pp. 14-15.

APPENDIX

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Existent

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OXYGEN, RESPIRATORY THERAPY

Existent

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State Medicaid Information Center
The National Governors' Association
Center for Policy Research

The National Governors' Association, founded in 1908 as the National Governors' Conference, is the instrument through which the governors of the fifty States and the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands collectively influence the development and implementation of national policy and apply creative leadership to state problems. The National Governors' Association membership is organized into eight standing committees on major issues: Agriculture; Criminal Justice and Public Protection; Executive Management and Fiscal Affairs; International Trade and Foreign Relations; Human Resources; Energy and Environment; Community and Economic Development; and Transportation, Commerce, and Technology. Subcommittees that focus on principal concerns of the governors operate within this framework. The Association works closely with the Administration and the Congress on state-federal policy issues from its offices in the Hall of the States in Washington, D.C.

The National Governors' Association Center for Policy Research serves as a vehicle for sharing knowledge of innovative programs among the States and provides technical assistance to governors. The Center also serves governors by undertaking demonstration projects and by providing research and developing policy options on a variety of crucial issues.

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